



A resource for physicians & patients

**INTAKE INFORMATION**

**Patient Name:** \_\_\_\_\_ **Date of Birth (DOB):** \_\_\_\_\_

**Phone (cell/land):** \_\_\_\_\_ **Address:** \_\_\_\_\_  
 Circle one

**How did you hear about us?** \_\_\_\_\_ **Reason for Treatment:** \_\_\_\_\_

**Primary Insurance:** \_\_\_\_\_ **Policy Number:** \_\_\_\_\_

**Insurance Phone:** \_\_\_\_\_ **Group ID:** \_\_\_\_\_

**Policy Holder Name:** \_\_\_\_\_ **Policy Holder DOB:** \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_ **Policy Number:** \_\_\_\_\_

**Insurance Phone:** \_\_\_\_\_ **Group ID:** \_\_\_\_\_

**Policy Holder Name:** \_\_\_\_\_ **Policy Holder DOB:** \_\_\_\_\_

**Physician Name:** \_\_\_\_\_ **Physician Phone:** \_\_\_\_\_

Is anyone coming to your home to check your blood pressure, provide nursing or therapy service? \_\_\_\_\_

**INSURANCE COVERAGE**

Office use only			
Effective Policy Dates:		Prior Auth. Needed:	
Co-payments:		Restricted No. visits/year:	
Annual Deductible:		Combined with other services?	
Amount Met:		Garment Coverage:	
% paid by insurance after deductible is met:		Out of Pocket Max:	
Comments:			